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**AUTHORIZATION TO RELEASE/DISCUSS *OUTGOING* HEALTHCARE INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize release of information from: ***Pecan Tree Pediatrics***

**FAX: 972-692-1128**

***1005 West Ralph Hall Parkway, Suite 135***

***Rockwall, Texas 75032***

**Phone: 972-772-3100**

***3360 West FM 544, Suite 910***

***Wylie, Texas 75098***

**Phone: 972-429-4800**

Information to be released/discussed to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE OF RELEASE** (please check one):

Changing Physicians   Legal  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.

**TYPE OF INFORMATION TO BE RELEASED**:

General Medical Records - excluding protected material

Specific Information Only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Practitioners Records

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROTECTED OR SENSITIVE INFORMATION**:

I understand that certain information cannot be released without specific authorization as required by law.

By initialing, I authorize release of the following protected information:

\_\_\_\_Mental Health Information:

\_\_\_\_Drug Abuse/Alcoholism Information

\_\_\_\_AIDS/HIV Test results- including high risk behavior

\_\_\_\_Other sexual information such as dysfunction or related diseases

**I UNDERSTAND THAT:**

\*\*I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of

my wish to Pecan Tree Pediatrics.

\*\*I can refuse to disclose some or all of my records, but if I do so, it could result in any improper diagnosis or treatment, denial of coverage of a claim for health benefits or other adverse consequences. Incomplete records may be labeled to inform the receiving of their status.

\*\*I can edit and/or obtain a copy of this release upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian or Authorized Representative Date